Can medical review committees control overservicing?

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Relentless growth in the volume of medical services is a serious problem with which Canada and most other industrialized nations must contend. Concern over the consequences of health care budgets hitting the financial wall has at least brought the debate over potential solutions into the political and public arenas. The article by Dr. Michael Wahn (see page 723 of this issue) does a disservice to this debate because of its failure not merely to acknowledge underlying biases but also to place the medical review of office practice in the context of the broader armamentarium of approaches to containing medical utilization.

Wahn's first assumption is that growth in the utilization of medical services is exclusively or even largely physician driven. This assumption ignores the recognized effects of such factors as aging of the population, availability and rate of change in technologies, drug therapies and treatment programs, expanded coverage of medical services, new government programs, constraints on hospital budgets, changes in the geographic distribution of physicians, consumer information and heightened expectations of the public.

Wahn's second assumption is that growth in utilization is equal to physician overservicing. Even though there may be a decreasing rate of return on people's health status for the increased dollars being spent on health care in most industrialized countries and even though significant numbers of medical interventions are performed without accrued benefits to patients, real advances in medical treatments, new diseases, prolonged life expectancy, expanded medical services coverage, improved access to medical services and other factors mentioned in the previous paragraph all contribute to the increase in medically necessary services.

Review of office practice is just one of a number of approaches to ameliorating growth in the utilization of medical services. It is but a subset of the larger sphere of utilization review now pervasive in the managed care programs used by health maintenance organizations and third-party payers in the United States. Utilization review involves the retrospective scrutiny of medical services delivered to determine whether the services were medically necessary and appropriate as well as the prospective review of patient care decisions. For example, a review by the Health Insurance Association of America[1] indicated that health care executives rated only high-cost case-management and discharge planning as being "very effective in reducing claims expenses with any regularity."

Utilization review is a case-finding, punitive approach to curbing growth in medical services. As Wahn argues, in a close-knit medical community the effects of practice review may be generalizable to a wider group of physicians. However, the development and implementation of clinical guidelines, another mechanism of utilization management, has the greater potential to influence a wide spectrum of health care professionals toward delivering necessary and appropriate medical services.[2,3]

Review of medical practice can be differentiated into voluntary peer review and record keeping, such as provided by the College of Physicians and Sur-

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geons of Ontario (CPSO) in its Peer Assessment Program, and the statutory requirement to ensure that public funds consumed in the provision of medical services have been expended appropriately. The latter form of review is the subject of Wahn's article.

The statutory review process typically must determine whether the service was medically necessary and performed in adherence to accepted professional standards and whether it was actually performed. As indicated in Wahn's article the determination of medical necessity has been the focus of efforts of the Manitoba Medical Review Committee. In Ontario, however, although the two requirements — medical necessity and ensuring the provision of claimed services — exist in legislation for the CPSO's Medical Review Committee the CPSO has focused its practice review largely on determining whether the claimed service was provided and appropriately documented. A major reason for this is the extreme difficulty in proving or disproving medical necessity, a subject Wahn does not address except to admit that it is all but impossible to determine for most specialties.

Wahn states that in Manitoba "in many cases the committee accepts the pattern without contacting the physician because of dealings with the physician in previous years or because the committee members know the nature of the practice." This practice clearly would not stand up to legal scrutiny. As the Ontario experience has shown, the the medical review process has taken on greater legal formality and complexity, with implications for the expandability of practice review and the added resources required to conduct it.

Because of the difficulty in determining medical necessity the main purpose of medical review is to ensure adherence to the requirements of the provincial benefit schedules. Even this is difficult, and frequently committees find themselves ruling not on the service but on whether the medical record can substantiate the claim for the service. If the record cannot do so, then the service is not paid for or a lesser benefit is given. The problem of adequate record keeping is not exclusive to physicians who are "statistical outliers" in their billing practices and was an important consideration in the creation of the voluntary Peer Assessment Program in Ontario.

Wahn mentions that the Manitoba Medical Review Committee reviews the practices of about 20% of the physicians in each specialty in Manitoba, "some because their overall patterns of practice for the preceding year diverged from the average for that specialty." Divergence from the average requires definition of the gradation of divergence. The frequency with which physicians are checked would clearly depend on the strictness of the statistical criteria.

In arguing that changes in medical fees and utilization are related Wahn specifically uses the "Ps and Qs" article by Lomas and associates[4] to substantiate his claims. However, that article has recently been challenged.[5,6]

Utilization can increase for reasons entirely consistent with improvements in health status. Questions of whether there is an improvement and whether the improvement justifies the expenditure remain for many treatments. Other than showing that physicians will alter their practice patterns in response to interventions from a medical review committee — a rather threatening event for most physicians — Wahn has added nothing to the debate about whether overservicing exists in general.

Medical review is unquestionably important, but it must be placed in perspective. Although it can and does save money the amounts are small and would appear to have a one-time effect on utilization. That is, if the actions of medical review committees and computer-assisted assessments changed billing practices by 5% annually, then changes in utilization would decrease by that amount in the start-up year and would be unaffected thereafter. Medical review committees have their place, but it is not in controlling utilization.

References

1. Gabel J, Fink S, Lippert C et al: *Trends in Managed Health Care*, Health Insurance Association of America, Washington, 1989
2. Linton AL, Peachey DK: Guidelines for medical practice: 1. The reasons why. *Can Med Assoc J* 1990; 143: 485-490
3. Peachey DK, Linton AL: Guidelines for medical practice: 2. A possible strategy. Ibid: 629-632
4. Lomas J, Fooks C, Rice T et al: Paying physicians in Canada: minding our Ps and Qs. *Health Aff (Millwood)* 1989; 8 (1): 80-102
5. Weinkauf DJ, Linton AL: Physician payment in Canada. *Health Aff (Millwood)* 1989; 8 (3): 235-239
6. Loyd M, Tsitanidis J: Clarifying Canadian physician payment [C]. *Health Aff (Millwood)* 1989; 8 (4): 201-204

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